

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3422

Item 12 Film

CERTIFICATE OF DEATH

6-9-58 et

Reg. Dist. No.

03407

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b> c. LENGTH OF STAY IN 1b <b>75 Yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6410 Old Washington Blvd.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b> d. STREET ADDRESS <b>6410 Old Washington Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Augusta A. Barklage</b> First Middle Last		4. DATE OF DEATH <b>March 16, 1958</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Margaret Schatz</b> Address <b>6410 Old Washington Blvd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>complications of age</b> <b>422.1</b> DUE TO <b>Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>General Arterio Sclerosis</b> (c) <b>54 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Decubitus ulcers</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>54 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1937</b> to <b>March 16, 1958</b> that I last saw the deceased alive on <b>March 16, 1958</b> , and that death occurred at <b>10:00</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B B Barklage</b> M.D.		ADDRESS (Street, city or town, state) <b>7609 Mason St</b> DATE SIGNED <b>3/17/58</b>	
PHYSICIAN'S NAME (Type) <b>B B Barklage</b>		<b>Elkridge, Howard, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/19/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Augustine</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Howard, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrose, Inc.</b> ADDRESS <b>1328 Sulphur Sp. Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 19 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>			

CERTIFICATE OF DEATH

The Death

NAME OF DECEASED John A. Smith		AGE 45		SEX Male		RACE White		DATE OF DEATH March 12, 1938	
PLACE OF DEATH City of Baltimore		STREET 1234		CITY Baltimore		STATE Maryland		COUNTY Baltimore	
OCCUPATION Carpenter		EDUCATION High School		MARRIAGE Married		SINGLE Single		WIDOWED Widowed	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF BURIAL Catholic Cemetery		DATE OF BURIAL March 15, 1938		BY WHOM John A. Smith	
SIGNATURE OF DECEASED John A. Smith		SIGNATURE OF WITNESS John A. Smith		SIGNATURE OF PHYSICIAN John A. Smith		SIGNATURE OF CLERK John A. Smith		SIGNATURE OF REGISTRAR John A. Smith	

BUREAU V. S.

MAR 19 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3423

CERTIFICATE OF DEATH

Reg. Dist. No. 03408

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt Airy</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 3 - Mt Airy</u>		d. STREET ADDRESS <u>3106 M St. NW</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna Belle</u> Middle <u>Becraft</u> Last <u></u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward S. Duwall</u>		14. MOTHER'S MAIDEN NAME <u>Catherine A. Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>Mrs. Frank Penn, Mt Airy, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January, 1958</u> , to <u>March, 1958</u> , that I last saw the deceased alive on <u>March 9, 1958</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.		ADDRESS (Street, city or town, state) <u>Mt. Airy</u> DATE SIGNED <u>3/10/58</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-13-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Waltz</u> ADDRESS <u>Winfield, Md.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Quinn</u>
		DATE <u>3-13-58</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3424 CERTIFICATE OF DEATH

Reg. Dist. No. 03409

1. PLACE OF DEATH o. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shaffers Convalescent Home</b>		d. STREET ADDRESS <b>503 Oakland Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>WEST</b> Last <b>WHITE COUNCELL</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>24</b> Year <b>19 58</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1871</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>19</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Wesley White</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Sophia Tannehill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Marbury Councell - 503 Oakland Rd.</b>		Address <b>Ellicott City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>9047</b> (b) <b>CARDIAC DECOMPENSATION</b> DUE TO (c) <b>2 MOS-</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRACTURED LEFT HIP</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>SIMPLE FALL</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>2</b> a. m. <b>1-17</b> 1958 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>SHAFFERS NURSING HOME</b>		20f. (City or town) (County) (State) <b>ELlicott City, How.</b>	
21. I certify that I attended the deceased from <b>1956</b> , to <b>3-21</b> , 1958, that I last saw the deceased alive on <b>3-21</b> , 1958, and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>ELlicott City</b> DATE SIGNED <b>3-25-58</b>			
ACTUAL SIGNATURE <b>PV Thorpe</b> M.D.			
PHYSICIAN'S NAME (Type) <b>PETER V. THORPE MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/26/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Com.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sam. J. Dickner &amp; Son - Balt 17</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 27 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Dr. L. Smith</b>			



CERTIFICATE OF DEATH

BUREAU V. S.

MAR 28 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03410

## 3425 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. LENGTH OF STAY IN 1b <u>Ellicott City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Pine Orchard</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Joshua</u> Middle <u>H.</u> Last <u>CROSS</u>				4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 27, 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Thomas S. Cross</u>				14. MOTHER'S MAIDEN NAME <u>Emma Stansfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss. Charity Cross</u>		Address <u>Ellicott City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Arteriosclerotic Cardio-Vascular Disease</u> (c) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 20, 1954</u> , to <u>Mar 30, 1958</u> , that I last saw the deceased alive on <u>Mar 29, 1958</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William F. Gassway</u>				ADDRESS (Street, city or town, state) <u>Ellicott City, Md.</u>			
NAME (Type) <u>William F. Gassway</u>				DATE SIGNED <u>3/30/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>		22d. LOCATION (City, town, or county) (State) <u>Alpha Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>				24a. REC'D BY REGISTRAR DATE <u>APR 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES E. SMITH		2. SEX Male		3. AGE 45	
4. DATE OF DEATH April 1, 1958		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. MEDICAL HISTORY Hypertension, Atherosclerosis	
10. SIGNATURE OF PHYSICIAN J. H. Jones, M.D.		11. SIGNATURE OF DECEASED (Blank)		12. SIGNATURE OF WITNESSES (Blank)	
13. SIGNATURE OF REGISTRAR (Blank)		14. SIGNATURE OF CLERK (Blank)		15. SIGNATURE OF CHIEF OF BUREAU (Blank)	

RECEIVED  
APR 2 1958  
BUREAU V. E.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3426

CERTIFICATE OF DEATH

Reg. Dist. No. 03411

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Scaggville</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Gorman Road</u>		d. STREET ADDRESS <u>Gorman Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Chester</u> Middle <u>Parfield</u> Last <u>GILBERT</u>		4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26 1880</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mining engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mining</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mrs Janet Gilbert</u>		Address <u>Scaggville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis C.V. Dis</u> DUE TO <u>Gen'l Arteriosclerosis</u> (c) <u>20 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/11/58</u> to <u>3/22/58</u> 19 <u>58</u> that I last saw the deceased alive on <u>3/22/58</u> 19 <u>58</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Warren</u> M.D.		ADDRESS (Street, city or town, state) <u>Colman Manor Md</u>	
PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>		DATE SIGNED <u>3-23-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>March 24, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Park Lincoln Cr.</u>		22d. LOCATION (City, town, or county) (State) <u>Colman Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. W. H. Donaldson</u> ADDRESS <u>Lanham Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

## MAYLAND STATE DEPARTMENT OF HEALTH—BALT MORE 18

MAR 26 1958

RECEIVED

3427 CERTIFICATE OF DEATH

03412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. LENGTH OF STAY IN 1b <b>X Ellicott City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Johns Lane</b>				/ d. STREET ADDRESS <b>St. Johns Lane</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCES LOUISE HARDMAN</b>				4. DATE OF DEATH Month Day Year <b>March 22 19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>May 18, 1890</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Catonsville, Md</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>James Henry Floyd</b>			14. MOTHER'S MAIDEN NAME <b>Wilhelmina Umbaugh</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Carl Myers, Ellicott City, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-20</b> 19 <b>58</b> to <b>3-22</b> 19 <b>58</b> , that I last saw the deceased alive on <b>3-17</b> 19 <b>58</b> , and that death occurred at <b>8:05A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>46 Church Road</b> DATE SIGNED <b>3/22/58</b>							
ACTUAL SIGNATURE <b>Thomas F. Herbert</b> M.D.			PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D. Ellicott City, Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-25-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F.C. Higinbotham, Ellicott City, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BOSTON, 18

NAME OF DECEASED: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF BIRTH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF INTERMENT: [illegible]

PLACE OF INTERMENT: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE: [illegible]

RECEIVED  
MAR 26 1938  
BUREAU V. S.

3428

## CERTIFICATE OF DEATH

Reg. Dist. No.

03413

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poplar Springs</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. # 3, Mt. Airy</b>				/d. STREET ADDRESS <b>R.F.D. # 3 Mt. Airy</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Howard</b> Last <b>Hardy</b>				4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1880</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Howard Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles H. Hardy</b>				14. MOTHER'S MAIDEN NAME <b>Miranda Young</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs Sadie M. Hardy, Mt. Airy, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arterio Sclerosis</b> DUE TO (c) <b>Yes</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Yes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 1, 1945</b> , to <b>Mar 1, 1958</b> , that I last saw the deceased alive on <b>Mar 1, 1958</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. M. Van Poole</b> M.D.				ADDRESS (Street, city or town, state) <b>Mt Airy, Md</b>		DATE SIGNED <b>3-1-58</b>	
PHYSICIAN'S NAME (Type) <b>C. M. Van Poole</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 4, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Springs Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Poplar Springs, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Mohan</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 5 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Ellen Couch</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

5 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3429

## CERTIFICATE OF DEATH

03414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>MILUM</u> First <u>Franklin</u> Middle <u>Johnson</u> Last		4. DATE OF DEATH <u>March</u> Month <u>27</u> Day <u>19-58</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hammer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Fisher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>444</u>	
17. INFORMANT <u>Mrs Alice Delfk - Woodbine, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Congestive Failure,</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Edema, Arteriosclerotic heart disease,</u> DUE TO (c) <u>Arteriosclerosis generalis, Senile degeneration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Jan 58 to 27 March 58</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>27 March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>27 March</u> , 19 <u>58</u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>27 March 58</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>Sykesville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3-30-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Liberty Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Pisbon, Howard Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hight</u> ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 31 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. Search</u>	

MAR 31 1958

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3430

CERTIFICATE OF DEATH

Reg. Dist. No.

195

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Savage</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Savage</i>			
c. LENGTH OF STAY IN 1b <i>45 yrs</i>				d. STREET ADDRESS <i>Savage</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Albert</i> Last <i>Keeney</i>				4. DATE OF DEATH Month <i>March</i> Day <i>11</i> Year <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 29, 1876</i>	9. AGE (In years last birthday) <i>81</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>md state tobacco warehouse</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Israel Keeney</i>				14. MOTHER'S MAIDEN NAME <i>Rebecca Young</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>James Keeney, Savage, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uraemia</i> 422.1 DUE TO (b) <i>Cardio-Vascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>1 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan. 1, 1957</i> to <i>Mar. 11, 1958</i> that I last saw the deceased alive on <i>Mar. 11, 1958</i> , and that death occurred at <i>11:15 A.</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Frank E. Shipley</i> M.D.				ADDRESS (Street, city or town, state) <i>Savage, Md</i> DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>Frank E. Shipley, M.D.</i>				<i>Savage, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 14, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Savage Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Savage Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Reuben Connelley</i> ADDRESS <i>Laurel Md.</i>				24a. REC'D BY REGISTRAR <i>W. H. H. H.</i> DATE <i>MAR 18 '58</i>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
DISEASE OR INJURY		PERIOD OF ILLNESS		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. E

MAR 18 1938

RECEIVED



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

Item 18 Film 226 3-24-58 ams  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard Co.</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Poplar Springs</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy R.F.D. Nr. Poplar Springs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Larry</u> Middle <u>LeRoy</u> Last <u>Matthews</u>			4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1957</u>		9. AGE (In years last birthday) yrs. <u>4</u> Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min. <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Benjamin Smith</u>			14. MOTHER'S MAIDEN NAME <u>Hezel Davis Matthews</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hazel Davis Matthews Mt. Airy, R.F.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Viral pneumonitis</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Woodbine</u>	(County) <u>Md.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>B.O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>March 6, 1958</u>	
EXAMINER'S NAME (Type) <u>B.O. Thomas, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 8</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	22d. LOCATION (City, town, or county) <u>Woodbine</u>	(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u>		ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Jones</u>

2269344XV2

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 10 1959

RECEIVED

St. Olive

March 8

1959

Baltimore, Md.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3432 Item 9 Film 227 4-1-58 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

03417

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Scaggsville</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Simpsonville</b>			
				f. STREET ADDRESS			
				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles Robert Myers</b>			4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>19 58</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/11/82</b>		9. AGE (In years last birthday) <b>76 7/8</b> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>John Myers</b>			14. MOTHER'S MAIDEN NAME <b>Lydia Dorsey</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-34-0220</b>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 19</b> , 19 <b>58</b> , to <b>March 22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>March 19</b> , 19 <b>58</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>JWB</b>		M.D. <b>J. W. Bird, M. D.</b>		ADDRESS (Street, city or town, state) <b>Sandy Spring, Maryland</b>		DATE SIGNED <b>3/23/58</b>	
PHYSICIAN'S NAME (Type) <b>J. W. Bird, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/26/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Locust Chapel,</b>		22d. LOCATION (City, town, or county) (State) <b>Simpsonville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sander</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 26 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>Robert L. Sander</b>			

CERTIFICATE OF DEATH

8135

Name of deceased		John K. Jones	
Sex		Male	
Age		45	
Date of birth		1910	
Place of birth		Maryland	
Occupation		Teacher	
Cause of death		Heart Disease	
Date of death		March 26, 1958	
Place of death		Home	
Signature of physician		<i>[Signature]</i>	
Signature of registrar		<i>[Signature]</i>	
Signature of informant		<i>[Signature]</i>	

**RECEIVED**  
MAR 26 1958  
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3433

## CERTIFICATE OF DEATH

Reg. Dist. No.

03418

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Rockville</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hattie Frances Powell</u>		4. DATE OF DEATH Month Day Year <u>March 4 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 29, 1900</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Louis Hrazier</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Stanton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>Walter W. Powell</u>		Address <u>1231 Division St. Balt</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia, cachexia</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>uncontrolled diabetes</u> DUE TO (c) <u>extensive arteritis of lower extremities</u> 490X		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>several years</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 3</u> , 19 <u>58</u> , and that death occurred at <u>1:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Bernard R. Gale</u>		M.D. <u>37 central Avenue</u>	
PHYSICIAN'S NAME (Type) <u>Bernard R. Gale</u>		<u>SYKESVILLE, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-8-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Daisy</u>		22d. LOCATION (City, town, or county) (State) <u>Daisy, Howard Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Knight</u>		ADDRESS <u>Ogdenville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Couch</u>	



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. PLACE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF INTERMENT		14. DATE OF INTERMENT		15. TIME OF INTERMENT	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF CLERK		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED	

BUREAU V. 1

MAR 10 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3434

## CERTIFICATE OF DEATH

### 03419

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harwood</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harwood Pk.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1915 Loudon Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary S. Robinson</b>		4. DATE OF DEATH Month <b>3</b> - Day <b>7</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-30-1875</b>
9. AGE (In years lost in day) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hampstead, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles W. Richards</b>		14. MOTHER'S MAIDEN NAME <b>Isadora Rupp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Lester L. Robinson</b>		Address <b>1915 Loudon Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apoplexy</b> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>General arteriosclerosis</b> DUE TO (c) <b>arterial hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>5 yr</b> <b>6 mo</b> <b>10 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 27, 1958</b> , to <b>March 7, 1958</b> , that I lost the deceased alive on <b>March 7, 1958</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B B Brumbaugh</b> M.D.		ADDRESS (Street, city or town, state) <b>5609 Main St</b>	
DATE SIGNED <b>3/7/58</b>			
PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>		<b>Elbridge 27 md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-10-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard N. Hubler</b>		ADDRESS <b>4107 Wilkens Ave.</b>	
24a. REC'D BY REGISTRAR <b>MAR 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Couch</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
Howard		M		M		W	
Place of Birth		Date of Birth		Date of Death		Cause of Death	
Howard		1915		1958		Heart Disease	
Residence		Occupation		Marital Status		Burial Place	
1215 Linden Ave.		Teacher		Married		Catholic	
Physician		Mortician		Funeral Home		Burial Place	
Dr. J. H. Robinson		J. H. Robinson		Robinson		Catholic	
Signature of Physician		Signature of Mortician		Signature of Funeral Home		Signature of Burial Place	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

MAR 11 1958

RECEIVED

Bureau of Vital Statistics  
4107 Wilkens Ave.  
Baltimore, Md.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03420

3435

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 22 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessups</b> c. LENGTH OF STAY IN 1b <b>X</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt.1 One Spot</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>Rt.1 One Spot</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIE MAE ROBINSON</b> First Middle Last 4. DATE OF DEATH <b>March 29, 1958</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>Colored</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Sept. 22, 1932</b> 9. AGE (In years last birthday) <b>25</b> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b> 11. BIRTHPLACE (State or foreign country) <b>Georgia</b> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Hinton Sanders</b> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <b>-</b> 17. INFORMANT <b>Eula C. High</b> Address <b>Rt. 1 One Spot, Maryland</b>		14. MOTHER'S MAIDEN NAME <b>Eula C. High</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Internal Hemorrhage</b> <b>8/2 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by automobile</b> 20c. TIME OF INJURY Month, Day, Year <b>12.01 AM 3/29 1958</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b> 20f. (City or town) (County) (State) <b>Rt.1 One Spot Howard Md</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Thomas F. Herbert</b> M.D. EXAMINER'S NAME (Type) <b>Thomas F. Herbert M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>3-29-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> 22b. DATE THEREOF <b>4/1/1958</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Ham</b> 22d. LOCATION (City, town, or county) (State) <b>Americus, Georgia</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b> ADDRESS <b>1808 N. Monroe St.</b> 24a. REC'D BY REGISTRAR <b>APR 2 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. Search</b>	

BUREAU V. S.

APR 3 1950

RECEIVED



3436

## CERTIFICATE OF DEATH

03421

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Haward</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Haward</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN TB <u>6 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffer Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine</u> First <u>Schneider</u> Middle <u>Missouri Road</u> Last		4. DATE OF DEATH <u>March 20 1958</u> Month <u>March</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 6 1867</u> 91 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Louisville Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Seibert</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bloomet</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Enneeth Shinn Jessup, Md</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uraemia</u> <u>422.1</u> DUE TO <u>Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>1 yr.</u> DUE TO (c) <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1, 1957</u> to <u>Mar. 20, 1958</u> , that I last saw the deceased alive on <u>Jan. 19, 1958</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED	
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.		DATE SIGNED <u>Mar 26 '58</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial March 22, 1958</u>		22b. DATE THEREOF <u>March 22, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Long Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Gooden</u> ADDRESS <u>Laurel, Md.</u>		24a. REGISTRAR'S SIGNATURE <u>W. H. ...</u> DATE <u>Mar 26 '58</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		DATE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		DATE OF BIRTH	

BUREAU V. S.

MAR 26 1958

RECEIVED

3437

## CERTIFICATE OF DEATH

Reg. Dist. No. 03422

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. LENGTH OF STAY IN 1b <b>Henryton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>DRENDA THOMAS</b>				4. DATE OF DEATH <b>March 2 1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 15, 1875</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>George Griffin</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Frances Brown, Henryton, Md</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocarditis</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Pulmonary</b> DUE TO <b>Idiopathic Hypertension Complicated by Pulmonary</b> (c) <b>Idiopathic Hypertension Complicated by Pulmonary</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2/22/58</b> , 19, to <b>3/1/58</b> , 19, that I last saw the deceased alive on <b>2/15/58</b> , 19, and that death occurred at <b>11:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. Barksdale</b> M.D.				ADDRESS (Street, city or town, state) <b>524 N. Gay St. Baltimore, Md</b> DATE SIGNED <b>3-2-58</b>			
PHYSICIAN'S NAME (Type) <b>L. Barksdale M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-6-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Liberty</b>		22d. LOCATION (City, town, or county) (State) <b>Alpha, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham</b> ADDRESS <b>Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
JAMES H. HARRIS		M		45		W		1910		BALTIMORE, MD		1958		BALTIMORE, MD		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
13. FULL NAME OF PHYSICIAN		14. FULL NAME OF NURSE		15. FULL NAME OF CHAPLAIN		16. FULL NAME OF MINISTER		17. FULL NAME OF OTHER		18. FULL NAME OF OTHER		19. FULL NAME OF OTHER		20. FULL NAME OF OTHER		21. FULL NAME OF OTHER		22. FULL NAME OF OTHER		23. FULL NAME OF OTHER		24. FULL NAME OF OTHER	
DR. J. H. HARRIS		MISS J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS	
19. FULL NAME OF OTHER		20. FULL NAME OF OTHER		21. FULL NAME OF OTHER		22. FULL NAME OF OTHER		23. FULL NAME OF OTHER		24. FULL NAME OF OTHER		25. FULL NAME OF OTHER		26. FULL NAME OF OTHER		27. FULL NAME OF OTHER		28. FULL NAME OF OTHER		29. FULL NAME OF OTHER		30. FULL NAME OF OTHER	
MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS	
31. FULL NAME OF OTHER		32. FULL NAME OF OTHER		33. FULL NAME OF OTHER		34. FULL NAME OF OTHER		35. FULL NAME OF OTHER		36. FULL NAME OF OTHER		37. FULL NAME OF OTHER		38. FULL NAME OF OTHER		39. FULL NAME OF OTHER		40. FULL NAME OF OTHER		41. FULL NAME OF OTHER		42. FULL NAME OF OTHER	
MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS	
43. FULL NAME OF OTHER		44. FULL NAME OF OTHER		45. FULL NAME OF OTHER		46. FULL NAME OF OTHER		47. FULL NAME OF OTHER		48. FULL NAME OF OTHER		49. FULL NAME OF OTHER		50. FULL NAME OF OTHER		51. FULL NAME OF OTHER		52. FULL NAME OF OTHER		53. FULL NAME OF OTHER		54. FULL NAME OF OTHER	
MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS	
55. FULL NAME OF OTHER		56. FULL NAME OF OTHER		57. FULL NAME OF OTHER		58. FULL NAME OF OTHER		59. FULL NAME OF OTHER		60. FULL NAME OF OTHER		61. FULL NAME OF OTHER		62. FULL NAME OF OTHER		63. FULL NAME OF OTHER		64. FULL NAME OF OTHER		65. FULL NAME OF OTHER		66. FULL NAME OF OTHER	
MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS	
67. FULL NAME OF OTHER		68. FULL NAME OF OTHER		69. FULL NAME OF OTHER		70. FULL NAME OF OTHER		71. FULL NAME OF OTHER		72. FULL NAME OF OTHER		73. FULL NAME OF OTHER		74. FULL NAME OF OTHER		75. FULL NAME OF OTHER		76. FULL NAME OF OTHER		77. FULL NAME OF OTHER		78. FULL NAME OF OTHER	
MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS	
79. FULL NAME OF OTHER		80. FULL NAME OF OTHER		81. FULL NAME OF OTHER		82. FULL NAME OF OTHER		83. FULL NAME OF OTHER		84. FULL NAME OF OTHER		85. FULL NAME OF OTHER		86. FULL NAME OF OTHER		87. FULL NAME OF OTHER		88. FULL NAME OF OTHER		89. FULL NAME OF OTHER		90. FULL NAME OF OTHER	
MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS	
91. FULL NAME OF OTHER		92. FULL NAME OF OTHER		93. FULL NAME OF OTHER		94. FULL NAME OF OTHER		95. FULL NAME OF OTHER		96. FULL NAME OF OTHER		97. FULL NAME OF OTHER		98. FULL NAME OF OTHER		99. FULL NAME OF OTHER		100. FULL NAME OF OTHER		101. FULL NAME OF OTHER		102. FULL NAME OF OTHER	
MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS	

BUREAU V. 3

MAY 5 1958

RECEIVED

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3438

## CERTIFICATE OF DEATH

Reg. Dist. No. **03423**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City Rural</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt. 144 Mayfield</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City Rural</b> d. STREET ADDRESS <b>Rt. 144 Mayfield</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>JAMES H. TUCKER</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>March 20 19 58</b>									
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4-23-1875</b>		<b>9. AGE</b> (In years last birthday) <b>82</b> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days Hours Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days Hours Min.												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm Owner</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>					
<b>13. FATHER'S NAME</b> <b>Aaron Tucker</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>Joseph Miller, Ellicott City, Md</b>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Circulatory Collapse</b> DUE TO <b>Cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Thrombocytopenia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>1 hr</b> <b>20 years</b>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I attended the deceased from</b> <b>10-21</b> , 19 <b>57</b> , to <b>3-20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3-17</b> , 19 <b>58</b> , and that death occurred at <b>5:30 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>46 Church Road Ellicott City, Md</b> DATE SIGNED													
<b>ACTUAL SIGNATURE</b> <b>Thomas F. Herbert</b> M.D.				<b>PHYSICIAN'S NAME (Type)</b> <b>Thomas F. Herbert, M.D. Ellicott City, Md</b>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>3-24-58</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Good Shepherd</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Ellicott City, Md</b>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>F.C. Higinbotham, Ellicott City, Md</b>						<b>24a. REC'D BY REGISTRAR</b> DATE <b>MAR 26 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Alfred Smith</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH - BALTIMORE  
 CERTIFICATE OF DEATH

1. PLACE OF DEATH: \_\_\_\_\_  
 2. DATE OF DEATH: \_\_\_\_\_  
 3. TIME OF DEATH: \_\_\_\_\_  
 4. SEX: \_\_\_\_\_  
 5. AGE: \_\_\_\_\_  
 6. RACE: \_\_\_\_\_  
 7. OCCUPATION: \_\_\_\_\_  
 8. MARITAL STATUS: \_\_\_\_\_  
 9. PLACE OF BIRTH: \_\_\_\_\_  
 10. DATE OF BIRTH: \_\_\_\_\_  
 11. TIME OF BIRTH: \_\_\_\_\_  
 12. SEX OF BIRTH: \_\_\_\_\_  
 13. RACE OF BIRTH: \_\_\_\_\_  
 14. OCCUPATION OF BIRTH: \_\_\_\_\_  
 15. MARITAL STATUS OF BIRTH: \_\_\_\_\_  
 16. PLACE OF BIRTH OF FATHER: \_\_\_\_\_  
 17. DATE OF BIRTH OF FATHER: \_\_\_\_\_  
 18. TIME OF BIRTH OF FATHER: \_\_\_\_\_  
 19. SEX OF BIRTH OF FATHER: \_\_\_\_\_  
 20. RACE OF BIRTH OF FATHER: \_\_\_\_\_  
 21. OCCUPATION OF BIRTH OF FATHER: \_\_\_\_\_  
 22. MARITAL STATUS OF BIRTH OF FATHER: \_\_\_\_\_  
 23. PLACE OF BIRTH OF MOTHER: \_\_\_\_\_  
 24. DATE OF BIRTH OF MOTHER: \_\_\_\_\_  
 25. TIME OF BIRTH OF MOTHER: \_\_\_\_\_  
 26. SEX OF BIRTH OF MOTHER: \_\_\_\_\_  
 27. RACE OF BIRTH OF MOTHER: \_\_\_\_\_  
 28. OCCUPATION OF BIRTH OF MOTHER: \_\_\_\_\_  
 29. MARITAL STATUS OF BIRTH OF MOTHER: \_\_\_\_\_

BUREAU V. S.

MAR 26 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

3439 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03424

Item 7, Film G227, 4/7/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City rural</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 40 opposite Browns Cabins</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>STANLEY</b> Middle <b>CLIFTON</b> Last <b>WEBB</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-27-36</b>
9. AGE (In years last birthday) <b>21</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edmond Webb</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-34-8128</b>	
17. INFORMANT <b>Agnes Jones Webb</b>		Address <b>538 Bruce St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>823x Broken Neck (Due to auto accident)</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto went into ravine passenger thrown out of car</b>	
20c. TIME OF INJURY Month, Day, Year <b>1.40 a.m. 3-27-58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Ellicott City Howard Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Donald E. Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Donald E. Fisher</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-1-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Peter's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>V. Brooks Ruggold</b>		ADDRESS <b>14637 Carey St</b>	
24a. REC'D BY REGISTRAR <b>MAR 31 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3440 CERTIFICATE OF DEATH

03425

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenelg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenelg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>LOUISE</u> Last <u>ZEPP</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-1871</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Harry Lehman</u>				14. MOTHER'S MAIDEN NAME <u>Harriett A. Ridgely</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Ellsworth Linthicum, Glenelg, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the rectum</u> <u>154x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>1958</u> Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-3-1947</u> to <u>3-2-1958</u> , that I last saw the deceased alive on <u>3-1-1958</u> , and that death occurred at <u>9:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>							
ACTUAL SIGNATURE <u>Charles S. Whitaker, M.D.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u> <u>Clarksville, Maryland</u> <u>3-3-58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Linthicum Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Clarksville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19

MAR 5 1958

RECEIVED